Washington State Department of Labor & Industries
Workers' Compensation Services

Payment Policies for Healthcare Services
Provided to Injured Workers and Crime Victims

Chapter 25: Physical Medicine Services

Effective July 1, 2017

Link: Look for possible **updates and corrections** to these payment policies at:
www.lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched/2017/

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Definitions

- **Body regions:** For osteopathic manipulation treatment (OMT) services, body regions are defined as:
    - Head,
    - Cervical,
    - Thoracic,
    - Lumbar,
    - Sacral,
    - Pelvic,
    - Rib cage,
    - Abdomen and viscera regions,
    - Lower and upper extremities.

- **Bundled codes: Are procedure codes that are not separately payable because they are accounted for and included in the payment of other procedure codes and services.**

- **CPT® and local code modifiers mentioned in this chapter:**

  –1S Surgical dressings for home use

  Bill the appropriate HCPCS code for each dressing item using this modifier –1S for each item. Use this modifier to bill for surgical dressing supplies dispensed for home use.

  –25 Significant, separately identifiable evaluation and management (E/M) service by the same physician on the day of a procedure

  Payment is made at 100% of the fee schedule level or billed charge, whichever is less.

  –52 Reduced services

  Payment is made at the fee schedule level or billed charge, whichever is less.

- **Work conditioning:** An intensive, work related, goal oriented conditioning program designed specifically to restore function for work.

- **Work hardening:** An interdisciplinary, individualized, job specific program of activity with the goal of return to work. Work hardening programs use real or simulated work tasks and progressively graded conditioning exercises that are based on the individual's measured tolerances. Work hardening provides a transition between acute care and successful return to work and is designed to improve the biomechanical, neuromuscular, cardiovascular, and psychosocial functioning of the worker.

Link: More information about L&I's work hardening program, including a list of approved work hardening providers, criteria for admission into a work hardening program, and other work hardening program standards is available on L&I's website at: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/RTW/WorkHard/.

This information is also available by calling the work hardening program reviewer at **360-902-4480**.

Payment policy: Electrical stimulators (including TENS)

Prior authorization

These HCPCS codes for **electrical stimulator devices for home use or surgical implantation** require prior authorization:

HCPCS code	Brief description	Additional coverage information
E0745	Neuromuscular stimulator for shock	This code is covered for **muscle denervation only**.
E0747	Electrical osteogenesis stimulator, not spine	—
E0748	Electrical osteogenesis stimulator, spinal	—
E0749	Electrical osteogenesis stimulator, implanted	Authorization for this code is subject to **utilization review**.
E0760	Osteogenesis ultrasound, stimulator	This code is covered for appendicular skeleton only (**not the spine**).
E0764	Functional neuromuscular stimulator	—

Services that can be billed

For electrical stimulator devices **used in the office setting**:

- When it is within the provider's scope of practice, a provider may bill professional services for application of stimulators with the CPT® physical medicine codes.
- Attending providers who aren't board qualified or certified in physical medicine and rehabilitation must bill local code **1044M**.

For electrical stimulator devices and supplies **for home use or surgical implantation**, HCPCS code **E0761** (Nonthermal electromagnetic device) is covered.

Services that aren't covered

For **use outside of medically supervised facility settings** (including home use and purchase or rental of durable medical equipment and supplies), the insurer doesn't cover:

- Transcutaneous Electrical Nerve Stimulators (TENS) units and supplies, *or*
- Interferential current therapy (IFC) devices, *or*
- Percutaneous neuromodulation therapy (PNT) devices.

Note: Use of these therapies will continue to be covered during hospitalization and in supervised facility settings.

For **home use or surgical implantation devices and supplies**, these HCPCS codes aren't covered:

- **E0731** (Conductive garment for TENS),
- **E0740** (Incontinence treatment system),
- **E0744** (Neuromuscular stimulator for scoliosis),
- **E0755** (Electronic salivary reflex stimulator),
- **E0762** (Transcutaneous electrical joint stimulation device system),
- **E0765** (Nerve stimulator for treatment of nausea and vomiting),
- **E0769** (Electric wound treatment device, not otherwise classified),
- **L8680** (Implantable neurostimulator electrode),
- **S8130** (Interferential current stimulator, 2 channel),
- **S8131** (Interferential current stimulator, 4 channel).

For home use or in medically supervised facility settings, CPT® code 64555 (Peripheral nerve neurostimulator) isn't covered.

Payment limits

These supplies are **bundled and not payable separately for office use**:

- **A4365** (Adhesive remover wipes),

- **A4455** (Adhesive remover per ounce),
- **A4556** (Electrodes, pair),
- **A4557** (Lead wires, pair),
- **A4558** (Conductive paste or gel),
- **A5120** (Skin barrier wipes box per 50),
- **A6250** (Skin seal protect moisturizer).

Additional information: Why the insurer doesn't cover TENS

On October 30, 2009, the State Health Technology Clinical Committee (HTCC) met in an open public meeting to review the evidence for Electrical Nerve Stimulation (ENS), including TENS, interferential current therapy (IFC), and percutaneous neuromodulation therapy (PNT), as treatments for acute and chronic pain.

Based on a review of the best available evidence of safety, efficacy, and cost effectiveness, the committee determined that ENS is non-covered for use outside of medically supervised facilities. Purchase or rental of TENS, IFC, and PNT equipment and supplies isn't covered.

The determination was finalized by the HTCC on November 20, 2009.

Link: Complete information on this HTCC determination is available at: www.hta.hca.wa.gov and at:

www.hca.wa.gov/hta/Pages/tens.aspx.

Payment policy: Massage therapy

Who must perform these services to qualify for payment

To qualify for payment, massage therapy services must be performed by:

- A licensed massage therapist, *or*
- Other covered provider whose scope of practice includes massage techniques.

Link: For more information, see WAC 296-23-250.

Services that can be billed

Massage therapists must bill CPT® code **97124** for all forms of massage therapy, regardless of the technique used. The insurer won't pay massage therapists for additional codes.

Requirements for billing

Massage therapists must bill CPT® code **97124** for all forms of massage therapy, regardless of the technique used. Massage therapists must also use CPT® code **97124** for evaluations and reevaluations.

Massage therapists must bill their usual and customary fee and document the duration of the massage therapy treatment.

Documentation must support the units of service billed. Document the amount of time spent performing evaluations and reevaluations as well as the treatment.

Payment limits

Massage therapy is paid at **75%** of the maximum daily rate for PT and OT services, *and*

The daily maximum allowable amount is **$95.21**.

These are bundled into the massage therapy service and aren't separately payable:

- Application of hot or cold packs,
- Anti-friction devices,
- Lubricants (for example, oils, lotions, emollients).

Link: For more information, see WAC 296-23-250.

Payment policy: Osteopathic manipulative treatment (OMT)

Who must perform these services to qualify for payment

Only osteopathic physicians may bill for OMT services.

Services that aren't covered

CPT® code **97140** isn't covered for osteopathic physicians.

Requirements for billing

OMT includes pre and post service work (for example, cursory history and palpatory examination). E/M office visit service may be billed in conjunction with OMT only when all of the following conditions are met:

- When the E/M service constitutes a significant separately identifiable service that exceeds the usual pre and post service work included with OMT, *and*
- The worker's record contains documentation supporting the level of E/M service billed, *and*
- The E/M service is billed using **modifier –25**. Without **modifier –25**, the insurer won't pay for E/M codes billed on the same day as OMT.

Note: The E/M service may be caused or prompted by the same diagnosis as the OMT service. A separate diagnosis isn't required for payment of E/M in addition to OMT services on the same day.

Payment limits

The insurer may reduce payments or process recoupments when E/M services aren't documented sufficiently to support the level of service billed. The CPT® book describes the key components that must be present for each level of service.

For OMT services, only one code is payable per treatment. This is because codes for **body regions** ascend in value to accommodate the additional **body regions** involved.

Example: If three body regions were manipulated, one unit of the correct CPT® code would be payable.

(See definition of **Body regions** in Definitions at the beginning of this chapter.)

Payment policy: Functional capacity evaluation

Prior authorization

Requires prior authorization by the claim manager.

Who must perform these services to qualify for payment

To qualify for payment, a functional capacity evaluation must be performed by:

- Physicians who are board qualified or certified in physical medicine and rehabilitation, *or*
- Physical and occupational therapists.

Services that can be billed

Standard Functional Capacity Evaluation

1045M is used to bill the Standard Functional Capacity Evaluation. When billing for this service:

- Units of service must be billed. 1 hour of direct time = 1 unit of service.
- The fee for 3-6 units of service is $758.85.
- A maximum of six units may be billed.
- Each provider must bill independently for their time.
- Time accumulates regardless of the number of days. Evaluations will involve at least 3 hours of face-to-face time. The fee for 1 unit of service is $126.48and the fee for 2 units of service is $252.95.

Supplemental Functional Capacity Evaluation

1098M is used to bill the Supplemental Functional Capacity Evaluation. Use this code when billing more than 6 hours of time beyond a Standard Functional Capacity Evaluation or for follow up testing. When billing for this service:

- Units of service must be billed. 1 hour of direct time = 1 unit of service.
- The fee for each 1 unit of service is $126.48.
- A maximum of six units may be billed.

- Each provider must bill independently for their time.
- Time accumulates regardless of the number of days.

Requirements for billing

Eligible providers must bill their usual and customary fee for Standard Functional Capacity Evaluations and Supplemental Functional Capacity Evaluations.

When the service is performed by multiple providers, each provider must bill for the amount of direct 1:1 time spent performing the evaluation using their individual provider account number.

These services include testing, a summary of findings, and full evaluation report. All summary reports must be submitted within 10 days of when the service was performed and full evaluation reports within 30 days.

 **Note:** Ensure all documentation is submitted before billing or the bill may be denied

Examples of billing options for multiple provider evaluations

Scenario: The Occupational Therapist (OT) performed 3.2 hours of direct time and the Physical Therapist (PT) performed 0.8 hours of direct time for a Standard FCE.

OT:	Bill 3 units of **1045M**
PT:	Bill 1 unit of **1045M**
Total units billed: 4 **Maximum fee of $758.85**	

Documentation must include:

1) A summary of findings- State fund, in-state claims complete the Summary Report Form F245-434-000. Out of state claims complete a summary of findings equivalent to F245-434-000; and

2) Full evaluation report demonstrating:

- L&I's minimum evaluation elements were met; *and*
- Duration of the evaluation. Each provider must separately document the amount of direct 1:1 time spent performing the service; *and*
- Signature and date of all evaluators.

For follow up testing, include:

- Date of service, worker name, claim number and a summary of test findings, *and*
- List of all tests that were performed, *and*
- Results of all testing performed, *and*
- Duration of the service. Each provider must separately document the amount of direct 1:1 time spent performing the service, *and*
- Signature and date of all evaluators.

Note: Documentation must clearly note who performed each service and how much time each individual provider spent providing the direct 1:1 evaluation. Include this information on both the summary of findings and full evaluation report.

Supplemental Functional Capacity Evaluation

1) For use when standard evaluation length is more than 6 hours.

Examples:

- Evaluating multiple jobs with opposite physical demands
- Performing a whole body and upper extremity focused evaluation
- Symptomatic neurological disease impacting testing tolerance

AND/OR

2) For use when follow up testing is indicated after completion of a Standard FCE.

- The Attending Provider and/or Vocational Provider determined additional testing is needed to facilitate return to work decisions.

Not Covered:

- Additional time to perform missed or forgotten testing
- Updates to an incomplete/conflicting report

Payment limits

Standard and Supplemental Functional Capacity Evaluations may only be billed once per worker every 30 days.

If the service is performed by multiple providers, the maximum fee applies once per worker irrespective of how many providers and/or provider types performed the evaluation.

If the worker has multiple claims, the maximum fee applies once per worker irrespective of the number of claims a worker may have.

Note: Standard and Supplemental Functional Capacity Evaluations may be provided over multiple days. If this occurs, the bill must span the dates of service to reflect the actual dates in which the evaluation was performed. For example, if the evaluation began on January 1st and was completed on January 3rd, the bill will reflect the "From Date of Service" as January 1st and the "To Date of Service" as January 3rd.

Multiple Claims: Split Billing: Refer to the General Provider Billing Manual F248-100-000.

Payment policy: Physical medicine CPT® codes billing guidance

Timed codes

Some physical medicine services (such as ultrasound and therapeutic exercises) are billed based on the number of minutes spent performing the service. These services are referred to as "timed services" and are billed using "timed codes."

Timed codes can be identified in CPT® by the code description. The definition will include words such as "each 15 minutes."

Providers **must document** in the daily medical record (chart note and flow sheet, if used):

- The amount of time spent for each time based service performed, *and*
- The specific interventions or techniques performed, including:
  - Frequency and intensity (if appropriate), *and*
  - Intended purpose of each intervention or technique.

Simply documenting the procedure code and the amount of time the service is

performed is insufficient and may result in denial of the bill or recoupment of payment. All documentation **must be submitted** to support your billing (for example, flow sheets, chart notes, and reports).

Note: Documenting a range of time (for example, 8-22 minutes) for a timed service isn't acceptable. Providers must document the actual amount of minutes spent performing the service.

The **number of units you can bill** is:

- Determined by the time spent performing each "timed service," *and*
- Constrained by the total minutes spent performing these services on a given day.

To obtain the total minutes spent performing time based services, add together the minutes spent performing each individual time based service.

To obtain the number of units that can be billed for these services, use the table below.

If the combined duration of all time based services is **at least**…	**and less than**…	Then, when **billing**, **report**:
8 minutes	**23** minutes	**1** unit
23 minutes	**38** minutes	**2** units
38 minutes	**53** minutes	**3** units
53 minutes	**68** minutes	**4** units
68 minutes	**83** minutes	**5** units
83 minutes	**98** minutes	**6** units
98 minutes	**113** minutes	**7** units
113 minutes	**128** minutes	**8** units

Note: The above schedule of times doesn't imply that any of the first eight minutes should be excluded from the total count. The timing of active treatment counted includes all direct treatment time.

For **example**, if you perform:

- **10 minutes** of CPT® **97110** (therapeutic exercises), *and*

- **12 minutes** of CPT® **97140** (manual therapy),

… you have performed **22 minutes** of timed code services. This equates to **one unit of service** that can be billed. Since the most time was spent performing manual therapy, **bill one unit of 97140**.

Examples of how to document and bill timed codes

The following examples show how the required elements of interventions can be documented and billed. These examples aren't reflective of a complete medical record for the patient's visit. The other elements of reporting (SOAP) **also must be documented**.

Example 1:

Procedural intervention	Specific intervention	Purpose	Treatment time
Therapeutic exercise	Left leg straight leg raises x 4 directions; 3 lbs. each direction. 10 reps x 2 sets	Strength and endurance training for lifting	**20 minutes**
Neuromuscular reeducation	One leg stance, 45 seconds left; 110 seconds on right using balance board x 2 sets each	Normalize balance for reaching overhead	**15 minutes**
Cold pack	Applied to left knee	Decrease edema	10 minutes
			Total treatment time = 45 minutes
			Total timed intervention (treatment time spent performing timed services) = **35 minutes**

A maximum of **two units** of timed services can be billed. Correct billing for the services documented is:

- **97110** (Therapeutic exercise) x 1 unit, *and*
- **97112** (Neuromuscular reeducation) x 1 unit.

Example 2:

Procedural intervention	Specific intervention	Purpose	Treatment time
Attended E-Stim and Ultrasound performed simultaneously	5mA right forearm 1.5 W/cm^2 ; 100% right forearm	Increase joint mobility	**8 minutes**
Whirlpool	Heat bath to right forearm and hand	Facilitate movement; reduce inflammation	8 minutes
Therapeutic exercise	Active assisted ROM to right wrist; flexion/extension; 15 reps x 2 sets	Increase motion and strength for gripping	**10 minutes**
			Total treatment time = 26 minutes
Total timed intervention (treatment time spent performing timed services) = **18 minutes**			

A maximum of **one unit** of timed services can be billed. Correct billing for the services documented is:

- **97110** (Therapeutic exercise) x 1 unit, *and*
- **97022** (Whirlpool) x 1 unit.

Prohibited pairs: What CPT® codes can't be billed together

A therapist can't bill any of the following pairs of CPT® codes for outpatient therapy services provided simultaneously to one or more patients **for the same time period**:

- Any two codes for "therapeutic procedures" requiring direct, one-on-one patient contact, *or*
- Any two codes for modalities requiring "constant attendance" and direct, one-on-one patient contact, *or*
- Any two codes requiring either constant attendance or direct, one-on-one patient contact, as described above (for example, any CPT® codes for a therapeutic procedure with any attended modality CPT® code), *or*
- Any code for therapeutic procedures requiring direct, one-on-one patient contact with the group therapy code (for example, CPT® code **97150** with CPT® code **97112**), *or*
- Any code for modalities requiring constant attendance with the group therapy code (for example, CPT® code **97150** with CPT® code **97035**), *or*
- An untimed evaluation or reevaluation code with any other timed or untimed codes, including constant attendance modalities, therapeutic procedures, and group therapy.

Determining what time counts towards timed codes

Providers report the code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services:

- Pre and post delivery services aren't counted in determining the treatment service time. In other words, the time counted as "intra-service care" begins when the therapist or physician (or a PT or OT assistant under the supervision of a physician or therapist) is working directly with the patient to deliver treatment services.
- The patient should already be in the treatment area (for example, on the treatment table or mat or in the gym) and prepared to begin treatment.
- The time counted is the time the patient is treated.
- The time the patient spends not being treated because of the need for toileting or resting shouldn't be billed. In addition, the time spent waiting to use a piece of equipment or for other treatment to begin isn't considered treatment time.

Regardless of the number of units billed, the daily maximum fee for services won't be exceeded.

Note: For more information about L&I's PT, OT, and massage therapy policies, see: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/RTW/Therapy/.

Payment policy: Physical therapy (PT) and occupational therapy (OT)

Who must perform these services to qualify for payment

PT services

PT services must be ordered by the worker's attending doctor, nurse practitioner, or the physician's assistant for the attending doctor. The services must be provided by a:

- Licensed physical therapist, *or*
- Physical therapist assistant serving under a licensed physical therapist's direction, *or*
- Athletic trainer serving under a licensed physical therapist's direction.

Link: For more information, see WAC 296-23-220.

OT services

OT services must be ordered by the worker's attending doctor, nurse practitioner, or the physician's assistant for the attending doctor. The services must be provided by a:

- Licensed occupational therapist, *or*
- Occupational therapy assistant serving under a licensed occupational therapists direction.

Link: For more information, see WAC 296-23-230.

Physical medicine services

Physical medicine services may be provided by:

- Medical or osteopathic physicians who are board qualified or board certified in physical medicine and rehabilitation (physiatry), *or*
- Attending doctors who aren't board qualified or certified in physical medicine and rehabilitation. For non-board certified/qualified providers, special payment policies apply. (See Requirements for billing and Payment limits, below.)

Link: For more information, see WAC 296-21-290.

Who won't be paid for physical medicine services

- Physical or occupational therapist students, *or*
- Physical or occupational therapist assistant students, *or*
- Physical or occupational therapist aides, *or*
- Gym Supervisors

Services that can be billed

Physical and occupational therapists must use the appropriate CPT® and HCPCS codes **64550**, **95831-95852**, **95992**, **97010-97799**, and **G0283**. These therapists must bill the appropriate covered HCPCS codes for miscellaneous materials and supplies.

Note: Some of these codes aren't covered or are bundled. See these exceptions noted in the Services that aren't covered and Payment limits (Bundled items or services), below.

For information on Surgical dressings dispensed for home use, see Chapter 28: Supplies, Materials, and Bundled Services.

If more than one patient is treated at the same time, use CPT® code **97150**.

Note: For more information, see Billing guidance: Using physical medicine CPT® codes earlier in this chapter.

For PT and OT evaluations and reevaluations, bill using CPT® codes **97161** through **97168**.

To report the evaluation by the physician or therapist to establish a plan of care, use CPT® codes **97161 through** 97163 **or 97165 through 97167**.

To revise the plan of care by reporting the evaluation of a patient who has been under a plan of care established by the physician or therapist, use CPT® codes **97164** and **97168**.

Note: CPT® codes **97164** and **97168** have no limit on how often they can be billed.

Services that aren't covered

Physical medicine CPT® codes **97006**, **97033 and 97169-97172** aren't covered.

Low level laser therapy isn't a covered benefit. For more information, please review L&I's coverage decision for low level laser therapy.

Cryotherapy and compression devices for home use aren't covered benefits. For more information, please review L&I's coverage decision for cryotherapy and compression devices for home use.

Requirements for billing

Physical medicine services

Board qualified and board certified physiatrists bill for services using:

- CPT® codes **97010** through **97799**, and **95831** through **95852**, *or*
- CPT® code **64550** (payable only once per claim).

Non-board certified/qualified physical medicine attending providers may perform physical medicine modalities and procedures described in CPT® codes **97010-97750** if their scopes of practice and training permit it, but for these services **must bill local code 1044M**. (See Payment limits for local code **1044M**, below.)

Note: The description for local code **1044M** is "Physical medicine modality(ies) and/or procedure(s) by attending doctor who isn't board qualified or certified in physical medicine and rehabilitation." The maximum fee for the code is **$46.29**.

Payment limits

Physical medicine services

CPT® code **64550** is payable only once per claim, and is payable only to board certified/qualified physiatrists.

Non-board certified/qualified physical medicine providers won't be paid for CPT® codes

97010-97799.

Local code **1044M** is limited to six units per claim. After six units, the patient **must be referred** to a licensed physical or occupational therapist or physiatrist except when the attending doctor practices in a remote location where no licensed physical or occupational therapist or physiatrists is available.

Bundled items or services

- Activity supplies used in work hardening, such as leather and wood,
- Application of hot or cold packs, (this includes all forms of cryotherapy with or without compression. 97016 may **not** be used to bill for these services),
- Electrodes and gel,
- Exercise balls,
- Ice packs, ice caps, and ice collars,
- Thera-tape,
- Wound dressing materials used during an office visit and/or PT treatment.

Note: For complete lists of bundled codes, see Chapter 28: Supplies, Materials and Bundled Services.

Daily maximum for services

The daily maximum allowable fee for PT and OT services is $126.94.

Link: For more information, see WAC 296-23-220 and WAC 296-23-230.

The daily maximum allowable fee doesn't apply to:

- Physicians board certified in Physical Medicine, or
- Functional capacity evaluations FCEs), *or*
- Work hardening services, *or*
- Work evaluations, *or*
- Job modification/prejob accommodation consultation services.

When performed for the same claim for the same date of service, the daily maximum applies to CPT® codes **64550**, **95831-95852**, and **97010-97799**, and HCPCS code **G0283**.

Work conditioning programs are reimbursed as outpatient PT and OT under the daily fee cap.

If PT, OT, and massage therapy services are provided on the same day, the daily maximum applies once for each provider type.

If the worker is treated for two separate claims with different allowed conditions on the same date, the daily maximum will apply for each claim.

If part of the visit is for a condition unrelated to an accepted claim and part is for the accepted condition:

- Therapists must apportion their usual and customary charges equally between the insurer and the other payer based on the level of service provided during the visit.
- In this case, separate chart notes for the accepted condition should be sent to the insurer since the employer doesn't have the right to see information about an unrelated condition.

Untimed Services

Supervised modalities and therapeutic procedures that don't list a specific time increment in their description are limited to one unit per day. This applies to these CPT® and HCPCS codes:

- **97010-97004**,
- **97012**,
- **97014**,
- **97016**,
- **97018**,
- **97022**,
- **97024**,
- **97026**,
- **97028**,
- **97150**,
- **97161-97168**

- **G0283.**

Note: Providers must document the actual service provided including the intended purpose for each service. Simply documenting the procedure code is insufficient and may result in denial of the bill or recoupment of payment. All documentation **must be submitted** to support your billing (for example, flow sheets, chart notes, and reports).

Work conditioning: Guidelines

(See definition of **Work conditioning** in Definitions at the beginning of this chapter.)

- **Frequency**: At least three times per week and no more than 5 times per week.
- **Duration**: No more than 8 weeks for one set. One set equals up to 20 visits.
  - An additional 10 visits may be approved upon review of progress.
- **Plan of Care**: Goals are related to:
  - Increasing physical capacities, *and*
  - Return to work function, *and*
  - Establishing a home program allowing the worker to progress and/or maintain function after discharge.
- **Documentation**: Besides standard documentation, it must include return to work capacities, which may include lifting, carrying, pushing, pulling, sitting, standing, and walking tolerances.
- **Treatment**: May be provided by a single therapy discipline (PT or OT) or combination of both (PT and OT).
  - PT and OT visits accumulate separately and both are allowed on the same date of service.
  - Billing reflects active treatment. Examples include CPT® **97110**, **97112**, **97530**, **97535**, and **97537**.

Payment policy: Powered traction therapy

Services that can be billed

Powered traction devices are covered as a physical medicine modality.

Payment limits

The insurer won't pay any additional cost when powered devices are used.

Additional information: Why the insurer won't pay additional cost when powered devices are used

Published literature hasn't substantially shown that powered devices are more effective than other forms of traction, other conservative treatments or surgery. This policy applies to all FDA approved powered traction devices.

For more information go to:

www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/Pwdtractiondevices.asp

Payment policy: Work hardening

(See definition of **Work hardening** in Definitions at the beginning of this chapter.)

Prior authorization

Work hardening programs require:

- Prior approval by the worker's attending physician, *and*
- Prior authorization by the claim manager.

Providing **additional services** during a work hardening program is atypical and must be authorized in advance by the claim manager.

Note: Documentation must support the billing of additional services.

Program extensions must be authorized in advance by the claim manager and are based on:

- Documentation of progress, *and*
- The worker's ability to benefit from the program extension up to two additional weeks.

Who must perform these services to qualify for payment

Only L&I approved work hardening providers will be paid for work hardening services.

Services that can be billed

Work hardening

- For the evaluation, bill using local code **1001M**.
- For treatment, bill using CPT® codes **97545** and **97546**.

Services that aren't covered

Billing for less than two hours of service in one day (CPT® code 97545)

Services provided for less than two hours on any day don't meet the work hardening program standards. Therefore, the services must be billed outside of the work hardening program codes. This should be considered as an absence in determining worker compliance with the program.

> **Example:** The worker arrives for work hardening, but isn't able to participate fully that day.

Requirements for billing

Work hardening

CPT® codes should be billed that appropriately reflect the services provided.

A worker typically starts at four hours per day and gradually increases to 7-8 hours per day by week four.

Billing less than one hour of CPT® code 97546

After the first two hours of service on any day, if less than 38 minutes of service are provided **modifier –52** must be billed. For that increment of time:

- CPT® code **97546** must be billed as a separate line item with **modifier –52**, *and*
- The charged amount prorated to reflect the reduced level of service.

> **Example:** Worker completes 4 hours and 20 minutes of treatment. Billing for that date of service would include three lines:

Code	Modifier	Charged amount	Units
97545		Usual and customary	1
97546		Usual and customary	2
97546	**–52**	33% of usual and customary (completed 20 of 60 minutes)	1

Billing for services in multidisciplinary programs

Each provider must bill for the services that they are responsible for each day. Both occupational and physical therapists may bill for the same date of service.

Billing for evaluation and treatment on the same day (multiple disciplines)

If both the OT and the PT need to bill for one hour of evaluation and one hour of treatment on the same date of service, the services must be billed as follows:

If the **provider type** is…	and the **service** provided is…	Then **bill as:**
OT	1 hour of evaluation	1 unit of **1001M**
PT	1 hour of evaluation	1 unit of **1001M**
OT (or PT)	1 hour of treatment	1 unit of **97545** with **modifier –52** (billed amount proportionate to 1 hour)
PT (or OT)	1 hour of treatment	1 unit of **97546**

Examples of billing options for services in multidisciplinary programs

Scenario: The OT is responsible for the work simulation portion of the worker's program, which lasted four hours. On the same day, the worker performed two hours of conditioning/aerobic activity for which the PT is responsible.

The providers could bill for the six hours of services in either one of two ways:

Billing option 1		
PT:	1 unit **97545**	2 hours
OT:	4 units **97546**	4 hours
Total hours billed:		**6 hours**

Billing option 2		
OT:	1 unit **97545** + 2 units **97546**	2 hours 2 additional hours
PT:	2 units **97546**	2 hours
Total hours billed:		**6 hours**

Payment limits

Work hardening

Work hardening programs are authorized for up to four weeks. Only one unit of **97545** (first two hours) will be paid per day per worker and the total number of hours billed shouldn't exceed the number of hours of direct services provided.

These codes are subject to the following limits:

Code	Description	**Unit limit** (four week program)	Unit price
1001M	Work hardening evaluation	6 units (1 unit = 1 hour)	**$125.82**
97545	Initial two hours per day	20 units per program; Maximum of one unit per day per worker (1 unit = 2 hours)	**$148.68**
97546	Each additional hour	70 units per program Add-on, won't be paid as a stand-alone procedure per worker per day. (1 unit = 1 hour)	**$75.87**

Providers may only bill for the time that services are provided in the presence of the client. The payment value of procedure codes **97545** and **97546** takes into consideration that some work occurs outside of the time the client is present (for example, team conference, plan development).

Time spent in treatment conferences isn't covered as a separate procedure regardless of the presence of the patient at the conference. Job coaching and education are provided as part of the work hardening program. These services must be billed using CPT® codes **97545** and **97546**.

Program extensions

Additional units available for extended programs:

Code	Description	Six week program limit
1001M	Work hardening evaluation	no additional units
97545	Initial two hours per day	10 units (20 hours)
97546	Each additional hour	50 units (50 hours)

Additional information: L&I's work hardening program

More information about L&I's work hardening program, including a list of approved work hardening providers, criteria for admission into a work hardening program, and other work hardening program standards is available:

- At: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/RTW/WorkHard/, *or*
- By calling the work hardening program reviewer at **360-902-4480**.

Payment policy: Wound care

Prior authorization

Electrical stimulation for chronic wounds

If electrical stimulation for chronic wounds is requested for use on an outpatient basis, prior authorization is required using the following criteria:

- Electrical stimulation will be authorized if the wound hasn't improved following 30 days of standard wound therapy, *and*
- In addition to electrical stimulation, standard wound care must continue.

Note: In order to pay for electrical stimulation beyond 30 days, licensed medical personnel must document improved wound measurements within the past 30 days. (See Requirements for billing, below.)

Services that can be billed

Debridement

Therapists must bill CPT® **97597**, **97598**, or **97602** when performing wound debridement that exceeds what is incidental to a therapy (for example, whirlpool).

Wound dressings and supplies **sent home with the patient** for self-care may be billed with HCPCS codes appended with local **modifier –1S**.

Note: For wound dressings and supplies used in the office, see Payment limits, below.

Link: For more information on billing with local **modifier –1S**, see the Surgical dressings for home use section (Requirements for billing and Payment limits) of Chapter 28: Supplies, Materials, and Bundled Services.

Electrical stimulation for chronic wounds

Electrical stimulation passes electric currents through a wound to accelerate wound healing. Electrical stimulation is covered for the following chronic wound indications:

- Stage III and IV pressure ulcers,
- Arterial ulcers,
- Diabetic ulcers,
- Venous stasis ulcers.

To bill for electrical stimulation for chronic wounds, use HCPCS code **G0281**.

Link: For more information on electrical stimulation for chronic wounds, go to: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/elecStimofChronicWounds.asp

Requirements for billing

Debridement

When performing wound debridement that exceeds what is incidental to a therapy (for example, whirlpool), therapists must bill CPT® **97597**, **97598**, or **97602**.

Electrical stimulation for chronic wounds

In order to pay for electrical stimulation beyond 30 days, licensed medical personnel must document improved wound measurements within the past 30 days.

Payment limits

Debridement

Wound dressings and supplies used in the office are bundled and aren't payable separately.

Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules (Washington state laws) for physical medicine	Washington Administrative Code (WAC) 296-21-290: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-21-290
Becoming an L&I Provider	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/Becoming/
Billing instructions and forms	Chapter 2: Information for All Providers
Electrical stimulation of chronic wounds	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/elecStimofChronicWounds.asp
L&I's general policies and rules for **PT, OT,** and **massage therapy**	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/RTW/Therapy/
Massage therapy administrative rules	Washington Administrative Code (WAC) 296-23-250: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-23-250
Occupational therapy administrative rules	Washington Administrative Code (WAC) 296-23-230: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-23-230
Physical therapy administrative rules	Washington Administrative Code (WAC) 296-23-220: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-23-220
Powered traction devices for intervertebral decompression	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/Pwdtractiondevices.asp
Fee schedules for all healthcare professional services	L&I's website: http://feeschedules.Lni.wa.gov
Payment policies for **supplies, materials, and bundled services**	Chapter 28: Supplies, Materials, and Bundled Services
TENS coverage decision	State Health Technology Clinical Committee (HTCC) website: www.hta.hca.wa.gov and:

If you're looking for more information about…	Then go here:
	www.hca.wa.gov/hta/Pages/tens.asp
Work hardening program at L&I	Program reviewer: **360-902-4480** L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/RTW/WorkHard/
L&I's coverage decision for low level laser therapy	The coverage decision: http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/CovMedDev/SpecCovDec/LLLT.asp
L&I's coverage decision for cryotherapy and compression devices for home use	The coverage decision: http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/CryotherapyCompression.asp

- **Need more help?** Call L&I's Provider Hotline at **1-800-848-0811**